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DRUG INDUSTRY OVERCHARGING MEDICAID PRESCRIPTIONS COST TAXPAYERS MILLIONS OF EXTRA DOLLARS

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FRANKFORT -- Medicaid programs across the country are making millions of dollars in overpayments because of flaws and abuses in the way they buy prescription drugs for the poor, according to government and industry officials.

One federal study put the figure at $128 million a year. But reforms in Texas indicate it could be far more than that or, as one Texas Medicaid official put it, a "staggering" amount.

Using Texas as a guide, the same reforms in Kentucky could save the state about $3 million.

The problem, officials say, is that a system designed to save taxpayers' money has been thrown out of whack by pricing data often described in the pharmaceutical industry as "meaningless" or a "joke."

The system is distorted even further by drug companies that publish prices that are dramatically higher than the prices they actually charge pharmacies. The sales technique, called "playing the spread," allows some pharmacists a larger profit margin on Medicaid drugs and frequently forces companies that play by the rules to lose business.

In Florida, for example, Medicaid officials found they were paying an average of $1.08 too much for each prescription drug because the published prices were inflated. Other states cite examples of published prices' being triple what pharmacists really paid.

Pharmacists, in turn, claim they are being squeezed to death by paper work and by low payments from Medicaid and private insurance companies that also cover drug purchases for clients. And the pharmacists say that what some perceive as overpay-

ments are actually discounts they earn by being good businessmen.

Attempts to reform the system at the federal level and in many states have been stymied by intense political pressure.

"Its a dastardly system any way you go," said Kathleen McGee, vice president for trade and professional relations for Barr Laboratories Inc.

The system evolved gradually after Medicaid was established in 1965 as a joint federal-state program to bring health care to the poor and some aged, blind and disabled people. In 1985, there were 22 million people in the program.

Each state is allowed to administer its Medicaid program within broad limits set by the federal government. Federal money, which totaled $37.5 billion in 1985, pays for from 50 percent to 78 percent. In 1985, Medicaid paid $2.3 billion for outpatient prescription drugs.

Over the years, a system to pay pharmacies for prescription drugs was devised to ensure that Medicaid was getting not only a fair price but also good discounts as a bulk buyer of drugs and as a public service.

The reimbursement system tried to assure that Medicaid never paid more for outpatient drugs than private customers and that it paid much less in most cases.

To avoid large retail markups, the rule for Medicaid payments was that pharmacies would be reimbursed by the government only for the cost of the ingredients of the drugs plus a dispensing fee to cover expenses and give them some profit.

But many officials said those lower Medicaid prices weren't nearly as low as they should have been.

A crucial number

The critical factor in all the state and federal payment formulas is the price pharmacies pay for ingredients.

Since it would be impossible to ask every pharmacy what it pays, Medicaid programs try to get prices from manufacturers and from common reference books, known as the Red Book, Blue Book and Medispan. In most cases, the figures are provided to the publications by the drug companies.

But the publications don't print what average customers pay. Instead, they print what are known as Average Wholesale Prices, which theoretically represent how much it would cost an average pharmacy to buy each drug from a wholesaler or distributor. Those prices do not, however, take into account the wide variety of discounts routinely available to pharmacies.

Nonetheless, Average Wholesale Prices have become the primary building block not

only in most state and federal Medicaid payment formulas but also in many formulas used by private insurance companies as well.

And that is the heart of the controversy.

"The (Average Wholesale Price) is a joke," said Valerie Marzani, director of regulatory affairs for Rugby Laboratories, one of the largest U.S. generic drug manufacturing companies. "It has largely become a farce because many companies have abused it and continue to abuse it."

Many state Medicaid officials agreed.

The Average Wholesale Price "just doesn't mean anything. It has no connection to what pharmacists really purchase the drug for," said David Feinberg, a top Pennsylvania Medicaid official.

Others are just as quick to defend the numbers.

"They are realistic approximations of the prices pharmacists are getting across-the-board. Every kind of price that one would attempt to use for this, you have to understand, at some level is not going to be perfect," said Todd Dankmyer, vice president for communications of the National Association of Retail Druggists.

The trouble in Kentucky

But the experience in Kentucky and other states indicates that there is a problem.

In Kentucky, there are 340,000 Medicaid recipients. This fiscal year, Medicaid will spend about $600 million on them -- $35 million of it for outpatient prescription drugs.

Kentucky gets its prices from the medical reference books, plus periodic updates from some drug companies doing business in the state. It then automatically subtracts 5 percent from the Average Wholesale Prices and adds a $3.25 dispensing fee.

Early last year, Kentucky Medicaid officials developed "a general concern" that drug prices might be excessive, according to R. Hughes Walker, the state's Medicaid commissioner.

He said that after a number of drug companies complained -- and some produced documentation -- about inflated Average Wholesale Prices, he fired off a letter last summer to all companies doing business in Kentucky.

The letter said that pricing information given to Kentucky "sometimes bears little, if any, relationship to the prices at which the respective products actually are sold to pharmacies."

It went on to demand that the companies submit what pharmacists really pay for the drugs and not the published Average Wholesale Prices.

At first, there was little response, and some companies even refused to cooperate.

But then Medicaid officials began getting company catalogs, either on their own or from competitors, that listed the real drug prices that pharmacies were paying.

Walker said they discovered that at least one generic drug company had two catalogs -- one with Average Wholesale Prices, apparently to show to Medicaid officials for reimbursements, and another with its real, lower prices to show to pharmacies.

Since then, the state has lowered more than 400 prices in its list of 3,960 approved drug products.

Walker said that he had referred a number of cases to the state attorney general's office, but that there wasn't sufficient evidence of wrongdoing for any prosecutions. He said the state probably was losing millions of dollars because it couldn't get real drug prices.

Some of the price changes in Kentucky were small, but many others were substantial.

For example, state Medicaid officials said a drug called sulfinpyrazone, used to treat chronic gouty arthritis, was listed by one company, Zenith Laboratories, in the 1987 Red Book as having an Average Wholesale Price of 16.69 cents for each 250 mg. tablet (based on a bottle of 100 tablets).

But early this year, Medicaid officials in Kentucky said they discovered that it was being sold to pharmacies for only 8.88 cents a tablet -- 47 percent below the published Average Wholesale Price.

Michael Marion, Zenith Laboratories director of marketing, said prices changed so quickly in the generic drug business that it might take months for states or medical publications to catch up. In addition, he said there quite often were sales promotions that could change prices drastically.

He said his company tried to be a fair as it could in setting its Average Wholesale Prices. And in fact it recently cut the prices by an average of one- third, he said.

But regardless of where it comes from, an exaggerated price does a couple of things to turn a cost-containment system into a costly system.

Playing the spread

For one thing, it can be used as part of a sales technique called "playing the

spread," a variety of industry sources say.

For example, sulfinpyrazone, mentioned above, had a published Average Wholesale Price of 16.69 cents, and that is the price most states would pay pharmacies. But the real price was 8.88 cents. So there was a 7.81-cent spread, or difference, between the Average Wholesale Price and the actual price. Therefore a pharmacist buying that drug could make a larger profit, and Medicaid would overpay.

In addition, 28 of the 48 states with Medicaid drug-reimbursement programs have set up an additional formula to cut costs by encouraging pharmacies to dispense less-expensive versions of drugs with three or more sources.

The program is called Maximum Allowable Cost. What it does is to take all types of a particular drug and set a limit for payments, usually based on the median Average Wholesale Price. Thus if there are 10 types of penicillin with 10 prices, then the price of the fifth-costliest brand becomes the maximum allowable cost, or the most the state will pay.

But if the Average Wholesale Prices are greatly exaggerated, then the median is increased, and the state will pay an inflated amount.

Drug manufacturers and distributors are acutely aware of the problems "playing the spread" creates.

Ms. McGee of Barr Laboratories said her company had been squeezed out of some sales because other companies actually advertised that they had a better spread.

In fact, many companies routinely list Average Wholesale Prices and "your price" in their catalogs to show the spread.

As a result, customers have put pressure on Barr Laboratories to increase the Average Wholesale Price listing as much as possible, Ms. McGee said.

"It really catches the manufactures in the middle. It makes us look dishonest, when we're not," said Ms. McGee, who has worked as a private pharmacist and for an industry trade association.

Getting clobbered

Moreover, companies that publish real prices often get "clobbered" in the marketplace, said Ms. McGee and officials of other drug companies.

Ms. Marzani of Rugby Laboratories said her company got "nailed to the wall" after it responded to the Kentucky letter about inflated Average Wholesale Prices with a list of what wholesalers were really charging pharmacies.

And although Rugby is considered to have some of the highest prices among generic companies, the Kentucky list is replete with companies showing prices two and

three times what Rugby charges for the same drug.

Ms. Marzani said other companies clearly were giving inflated prices. In fact, she pointed to one company listed in the Kentucky book, Par Pharmaceuticals, that lists a price for the heart drug isosorbide dinitrate that is three times higher than Rugby's price.

The catch is that Rugby buys the drug from that company and sells it under its own label. "You find the sense in it," she said.

Robert Gunther, vice president and marketing for sales of Par Pharmaceuticals, said the problem may be that the state had not caught up with price changes. He said that his company sent out changes as quickly as it could and that if states "don't take that information and go into their computer and change it, then we certainly can't be held responsible for that."

George Jones, executive director of the Kentucky Pharmacists Association, said he had received some complaints from his members about companies' promoting the difference between Average Wholesale Prices and their prices.

"They were worried about the ethics . . . but we haven't seen any laws broken," he said, adding that use of that sales technique was "extremely limited."

Inflated prices

But the problem isn't only that some companies are exaggerating Average Wholesale Prices as a sales technique. A number of studies have demonstrated that the prices generally are inflated.

In 1985, the inspector general of the Department of Health and Human Services conducted a nationwide audit of drug prices.

It concluded that Average Wholesale Prices were, on the average, 16 percent too high. In fact, of the 3,469 drug purchases analyzed, all but 14 were made at less than the Average Wholesale Price.

What the auditors discovered was what was common knowledge in the industry: Practically all pharmacies -- big and small, and regardless of location -- got discounts on the drugs they bought and were not passing those savings on to Medicaid.

It is common practice, for example, for pharmacies to get a discount just for paying their bills on time. In addition, there are volume discounts, rebates and specials to cut prices even further below the Average Wholesale Price.

The audit said those discounts were not being passed on to Medicaid and added, "We estimate that as much as $128 million could be saved annually through changes in program policy and regulations which would restrict the use of AWP (Average Wholesale Prices) as an upper limit in drug reimbursements."

The audit plus subsequent federal attempts to restrict the use of Average Wholesale Prices set off a firestorm of protest in the drug industry. But other studies pretty much confirmed the basic finding.

Jerry Wells, the pharmacist consultant for Medicaid in Florida, said Average Wholesale Prices were like the sticker prices on new cars. "Everybody gets a discount," said Wells, who has worked as a private pharmacist and a manufacturers representative.

He said the state's audit showed that the stores' average discount from Average Wholesale Prices was about 13.6 percent. In fact, he said, many pharmacists didn't realize just how large a discount they were getting.

They discovered an average $1.08 discount from the Average Wholesale Price on each prescription, he said. In other words, Florida was paying $1.08 too much for each of more than 8 million drug claims.

Wells said the state also discovered instances of companies' raising their Average Wholesale Prices without raising their real prices, apparently just to increase the spread.

As a result, Florida came up with a new payment system and increased the dispensing fees. The overall savings was 28 cents on each prescription, or about $2.2 million.

Texas saves millions

In Texas, the savings were even greater.

Robert Harriss, an assistant commissioner in Texas' Medicaid program, said that a 1985 survey turned up hair-raising examples of exaggerated prices, including one brand of penicillin that had a Red Book price of $100, "but pharmacists were buying it all day long for $30."

As a result, Texas developed a new reimbursement system that also encouraged the use of less expensive generic drugs.

Even with greatly increased dispensing fees, he estimated the savings were around $17 million a year, or 13.8 percent of the state's Medicaid drug budget. The savings on the cost of drugs alone was about $11.5 million, or about 9 percent of the $125 million drug bill for the 1987 fiscal year, Harriss said.

The experience in Texas indicates that the overpayments could be as high as $3 million in Kentucky, or about 9 percent of the state's $35 million drug bill. But cost-containment systems in place in Kentucky could make it somewhat less.

Nationally, applying the 9 percent Texas saved on drugs alone could have cut $200 million from the Medicaid bill in 1985. But putting Texas' other reforms

into effect nationwide could mean millions more in savings.

The approach Texas and Florida, among others, are taking is to require manufacturers to tell them how much they are charging wholesalers for each drug. To that, they add a set percentage to allow everyone some profit. In addition, they take the listed Average Wholesale Price and subtract up to 10 percent. Then they will reimburse the lower of the two prices.

States like Kentucky that just subtract a set amount from the Average Wholesale Price are not really solving the problem because companies can raise their Average Wholesale Prices, said Wells of Florida. In addition, that system penalizes companies that have low markups between their direct prices and Average Wholesale Prices, he said.

Some states said they were reluctant to change their systems because they feared the new administrative costs would exceed any savings.

But Harriss said those fears were unfounded. Texas has one full-time pharmacist using a computer to update the rapid changes in thousands of drug prices.

Pharmacists upset

But for pharmacists, the issue isn't that Average Wholesale Prices are too high, but too low. And they think they have been blamed unfairly for a problem that they cannot control because they do not set the Average Wholesale Prices and they do not design the reimbursement systems.

They argue that they don't make much profit on Medicaid and, in many cases, even lose money.

Pharmacists also said that even if the Average Wholesale Prices were off somewhat, everything balanced out because states pay such low dispensing fees -- from around $2 to more than $5.

"It's a ludicrous proposition that pharmacists are gouging the public through AWP," said Dankmyer of the National Association of Retail Druggists, which claims its 30,000 independent pharmacies provide 81 percent of all Medicaid pharmaceutical services.

The argument put forth most emphatically by pharmacists is that if they pay below the Average Wholesale Prices for some drugs, it is because they are good businessmen and therefore gain "earned discounts."

Medicaid officials, in turn, argue that they must be "prudent" buyers with taxpayers' money and that everyone gets the discounts. Therefore, they said, pharmacies should pass their savings along to the state.

But attempts to do that have met bitter resistance from the National Association

of Retail Druggists and other pharmaceutical organizations.

The association led the fight to force the federal Health Care Financing Administration, which administers Medicaid and Medicare for the elderly, to retreat from proposed changes in 1985 that came up after the inspector general's audit discovered the overpayments. (Medicare does not have an outpatient drug program).

"We put a lot of pressure on the Health Care Financing Administration, and they backed off," Dankmyer said.

Tremendous pressure also was brought to bear by political action committees on officials in states that tried to make drastic changes.

Pennsylvania, for example, was preparing major changes. After a difficult battle, however, the drug companies "gathered up enough political power that they were able to head this off," said Feinberg of Pennsylvania's Medicaid office.

New federal proposals

No one could be found at the Health Care Financing Administration who was willing to discuss the controversy. However, spokeswoman Ann Hoffnar said it was likely to be resolved soon when the agency announced new rules on reimbursements.

The federal government is likely to set a limit on drug prices, then give states enough flexibility to work out their own reimbursement systems, said C. Ross Anthony, associate administrator for program development in the financing administration.

The changes, however, are opposed by pharmacy trade groups, several state Medicaid officials and others in the industry.

"The problem with most of the government programs is that the prices that they set more often become a ceiling than a floor. And they have this bad habit of being pressured down," said Ms. McGee of Barr Laboratories. "So everybody is rightly leery of fixed formulas."

---- INDEX REFERENCES ----

COMPANY: BARR PHARMACEUTICALS INC; RUGBY LABS; ZENITH LABORATORIES INC

NEWS SUBJECT: (Social Issues (1SO05); Social Welfare (1SO83); Government (1GO80); Economics & Trade (1EC26))

INDUSTRY: (Insurance Regulatory (1IN40); Commercial Property & Casualty Insurance (1CO35); Pharmaceuticals & Biotechnology (1PH13); Healthcare Services (1HE13); Healthcare Services Regulatory (1HE66); Ambulatory Healthcare Practices & Management (1AM98); Healthcare Regulatory (1HE04); Pharmacy (1PH23); Drugs (1DR89); Infection Control & Epidemiology (1IN02); Financial Services (1FI37); Antibiotics

(1AN81); Financial Services Regulatory (1FI03); Infectious Diseases (1IN99); Pharmaceuticals Cost-Benefits (1PH30); Pharmaceuticals Regulatory (1PH03); Drugstores (1DR73); Property & Casualty Insurance (1PR21); Healthcare (1HE06); Healthcare Cost-Benefits (1HE10); Corporate Insurance (1XO50); Insurance (1IN97); Ambulatory Care (1AM41); Prescription Drugs (1PR52))

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